



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

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VERIFICATION OF POST-GRADUATE MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to each program attended.

Educational Institution: _____ Address: _____ City/State/Zip: _____	Affiliated University: _____ Address: _____ City/State/Zip: _____						
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____ SSN: _____ DOB: _____ Other Name(s) Used: _____						
Program Participation to be completed by Institution Complete all items.	<ul style="list-style-type: none"> Use one section per department. If department is rotating or traditional, provide a schedule of rotations. Report Internships, Residencies and Fellowships separately. If the PGY is currently underway, report the expected completion date in the TO field. Report incomplete PGY's separately from successfully completed PGY's. 						
Complete all items.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; vertical-align: top;"> PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other </td> <td style="width: 70%; vertical-align: top;"> Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____ </td> </tr> <tr> <td style="vertical-align: top;"> PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other </td> <td style="vertical-align: top;"> Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____ </td> </tr> <tr> <td style="vertical-align: top;"> PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other </td> <td style="vertical-align: top;"> Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____ </td> </tr> </table>	PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other	Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____	PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other	Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____	PGY Year: _____ <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship <input type="checkbox"/> Research <input type="checkbox"/> Other	Department: _____ From (mm/dd/yyyy): _____ To (mm/dd/yyyy): _____ Successfully completed? Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress <input type="checkbox"/> Accreditation: ACGME <input type="checkbox"/> AOA <input type="checkbox"/> Not Accredited <input type="checkbox"/> Other <input type="checkbox"/> Explain: _____
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Unusual Circumstances to be completed by Institution Complete all items.	<ol style="list-style-type: none"> 1. Did this applicant ever take a leave of absence or break from training? Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Was this applicant ever placed on probation? Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Was this applicant ever disciplined or placed under investigation? Yes <input type="checkbox"/> No <input type="checkbox"/> 4. Did the instructors file any negative reports on this applicant? Yes <input type="checkbox"/> No <input type="checkbox"/> 5. Were any limitations or special restrictions placed on this applicant because of questions of academic incompetence, disciplinary problems or any other reasons? Yes <input type="checkbox"/> No <input type="checkbox"/> <p>Explain yes answers and any other unusual circumstances on a separate sheet.</p>						
CERTIFICATION AFFIX INSTITUTION OR NOTARY SEAL HERE	I certify that the information above is an accurate account of this individual's records and is true and correct. Print Name of <u>Program Director</u> (MD or DO): _____ Signature of <u>Program Director</u> : _____ Date: _____ Phone: _____ Fax: _____ Email: _____						

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.